

Request form for non-invasive prenatal testing of aneuploidies - PRENASCAN

Personal data of the patient (label):	Referring physician:
Name and surname: Birth identification number/ID number: Date of birth: Insurance: Gender: <input checked="" type="checkbox"/> Female Address: Diagnosis (ICD):	 (name, specialisation, identification number, workplace, stamp, signature)
Primary sample:	
<input type="checkbox"/> Peripheral blood (Streck Cell-Free DNA BCT CE, 10 ml non-coagulated blood)* <small>*After blood collection, it is necessary to invert the tube 10 times and store it at room temperature. The blood must be delivered to the laboratory within 2-3 days of collection!</small>	
Date and time of collection:	Date and time of indication (if different from the collection date):
Clinical data: (to be completed by the referring physician)	
Vanishing twin syndrome:* <input type="checkbox"/> YES <input type="checkbox"/> NO Is it a repeated blood collection for this examination? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<small>*) If YES: The examination can be performed in the case of vanishing twin syndrome only if it has been diagnosed by the 8th week of pregnancy, and the sample collection follows at least 8 weeks after the cessation of development of the second foetus.</small>	
Number of fetuses: <input type="checkbox"/> 1 <input type="checkbox"/> 2 → Is it: <input type="checkbox"/> Monozygotic <input type="checkbox"/> Dizygotic <input type="checkbox"/> Zygosity undetermined	
Pregnancy after IVF: <input type="checkbox"/> YES <input type="checkbox"/> NO PGT was conducted: <input type="checkbox"/> YES <input type="checkbox"/> NO Donated oocyte: <input type="checkbox"/> YES <input type="checkbox"/> NO Donor's age: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Weight (kg): _____ Date of last menstruation: _____	
Height (cm): _____ Gestational age at the time of collection Weeks: _____ + Days: _____	
Risk of T21 1/ _____ according to US:	
Risk of T18 1/ _____	
Risk of T13 1/ _____	
Is the patient taking anticoagulants (heparin-based)? <input type="checkbox"/> YES <input type="checkbox"/> NO Number of hours since the last medication dose:*	
<small>*) If the patient is taking anticoagulants (e.g., Fraxiparine, Clexane), there is a higher risk of an uninformative test result and the need for repeated collection. Blood collection must be done before the administration of the next dose of the medication (i.e., as far away as possible from the last dose).</small>	
Results will be sent to the following doctor's email: _____	
Informed consent* – The patient has been provided with the consent form and instructions regarding PRENASCAN, and the patient agrees:	
<input checked="" type="checkbox"/> With the examination of the sample Does the patient want to know the gender of the foetus? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> With the use of the sample for research purposes <small>NO: We will not report the gender of the foetus, but we analyse sex chromosomes, and in the case of abnormalities in sex chromosomes, we will report this finding, including the gender of the foetus!</small>	
Does the patient want to know additional findings? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If YES: We analyse the entire genome and report all findings of size 7Mb or larger. If NO: We analyse only chromosomes 21, 13, and 18, and abnormalities of the sex chromosomes.</small>	
<small>*) By submitting the request, the referring physician confirms that the patient or legal representative has signed the informed consent with the examination, which is either stored in the patient's documentation or attached to this request.</small>	
The examination is conducted by: GENNET, s. r. o., Laboratories GENNET, Pekařská 635/6, 158 00 Prague 5 – Jinonice, Tel: 226 231 691	
Laboratory notes:	
Date and time of sample/request reception: _____	Sample/request was received by: _____

